

Second Regular Session 119th General Assembly (2016)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type~~.

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~this style type~~ reconciles conflicts between statutes enacted by the 2015 Regular Session of the General Assembly.

SENATE ENROLLED ACT No. 165

AN ACT to amend the Indiana Code concerning Medicaid.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 11-10-3-7, AS AMENDED BY P.L.185-2015, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: Sec. 7. (a) If the department or a county incurs medical care expenses in providing medical care to an inmate who is committed to the department and the medical care expenses are not reimbursed, the department or the county shall attempt to determine the amount, if any, of the medical care expenses that may be paid:

(1) by a policy of insurance that is maintained by the inmate and that covers medical care, dental care, eye care, or any other health care related service; or

(2) by Medicaid.

(b) For an inmate who:

(1) is committed to the department and resides in a department facility or jail;

(2) incurs or will incur medical care expenses that are not otherwise reimbursable;

(3) is unwilling or unable to pay for the inmate's own health care services; and

(4) is potentially eligible for Medicaid (IC 12-15);

the department is the inmate's Medicaid authorized representative and may apply for Medicaid on behalf of the inmate.

(c) The department and the office of the secretary of family and



social services shall enter into a written memorandum of understanding providing that the department shall reimburse the office of the secretary for administrative costs and the state share of the Medicaid costs incurred for an inmate.

(d) Reimbursement under this section for reimbursable health care services provided by a health care provider, including a hospital, to an inmate as an inpatient in a hospital must be as follows:

(1) For inmates eligible and participating in the ~~Indiana check-up plan (IC 12-15-44.2)~~, **healthy Indiana plan (IC 12-15-44.5)**, the reimbursement rates described in ~~IC 12-15-44.2-14~~, **IC 12-15-44.5-5**.

(2) For inmates other than those described in subdivision (1) who are eligible under the Medicaid program, the reimbursement rates provided under the Medicaid program, except that reimbursement for inpatient hospital services shall be reimbursed at rates equal to the fee-for-service rates described in IC 16-21-10-8(a)(1).

Hospital assessment fee funds collected under IC 16-21-10 or the **healthy** Indiana ~~check-up~~ plan trust fund (IC 12-15-44.2-17) may not be used as the state share of Medicaid costs for the reimbursement of health care services provided to the inmate as an inpatient in the hospital.

SECTION 2. IC 12-7-2-137.8, AS ADDED BY P.L.213-2015, SECTION 126, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: Sec. 137.8. "Phase out period", for purposes of ~~IC 12-15-44.2~~ and IC 12-15-44.5, has the meaning set forth in IC 12-15-44.5-1.

SECTION 3. IC 12-7-2-140.5, AS AMENDED BY P.L.213-2015, SECTION 127, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: Sec. 140.5. "Plan", ~~means the following:~~ **for purposes of IC 12-15-44.2 and IC 12-15-44.5, has**

(1) ~~For purposes of IC 12-15-44.2, the meaning set forth in IC 12-15-44.2-1.~~

(2) ~~For purposes of IC 12-15-44.5, the meaning set forth in IC 12-15-44.5-2.~~

SECTION 4. IC 12-7-2-144.3, AS AMENDED BY P.L.3-2008, SECTION 91, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: Sec. 144.3. "Preventative care services", for purposes of ~~IC 12-15-44.2~~, **IC 12-15-44.5**, has the meaning set forth in ~~IC 12-15-44.2-2~~, **IC 12-15-44.5-2.3**.

SECTION 5. IC 12-15-44.2-1 IS REPEALED [EFFECTIVE JULY 1, 2016]. ~~Sec. 1: As used in this chapter, "plan" refers to the healthy Indiana plan established by section 3 of this chapter.~~



SECTION 6. IC 12-15-44.2-2 IS REPEALED [EFFECTIVE JULY 1, 2016]. Sec. 2: As used in this chapter, "preventative care services" means care that is provided to an individual to prevent disease; diagnose disease; or promote good health.

SECTION 7. IC 12-15-44.2-3 IS REPEALED [EFFECTIVE JULY 1, 2016]. Sec. 3: (a) The healthy Indiana plan is established:

(b) The office shall administer the plan:

(c) The department of insurance and the office of the secretary shall provide oversight of the marketing practices of the plan:

(d) The office shall promote the plan and provide information to potential eligible individuals who live in medically underserved rural areas of Indiana:

(e) The office shall, to the extent possible, ensure that enrollment in the plan is distributed throughout Indiana in proportion to the number of individuals throughout Indiana who are eligible for participation in the plan:

(f) The office shall establish standards for consumer protection; including the following:

(1) Quality of care standards:

(2) A uniform process for participant grievances and appeals:

(3) Standardized reporting concerning provider performance; consumer experience; and cost:

(g) A health care provider that provides care to an individual who receives health insurance coverage under the plan shall participate in the Medicaid program under IC 12-15:

(h) The office of the secretary may refer an individual who:

(1) has applied for health insurance coverage under the plan; and

(2) is at high risk of chronic disease;

to the Indiana comprehensive health insurance association for administration of the individual's plan benefits under IC 27-8-10.1:

(i) The following do not apply to the plan:

(1) IC 12-15-6:

(2) IC 12-15-12:

(3) IC 12-15-13:

(4) IC 12-15-14:

(5) IC 12-15-15:

(6) IC 12-15-21:

(7) IC 12-15-26:

(8) IC 12-15-31.1:

(9) IC 12-15-34:

(10) IC 12-15-35:

(11) IC 12-15-35.5:



(12) IC 16-42-22-10:

SECTION 8. IC 12-15-44.2-4 IS REPEALED [EFFECTIVE JULY 1, 2016]. Sec. 4. (a) The plan must include the following in a manner and to the extent determined by the office:

- (1) Mental health care services:
- (2) Inpatient hospital services:
- (3) Prescription drug coverage, including coverage of a long acting, nonaddictive medication assistance treatment drug if the drug is being prescribed for the treatment of substance abuse:
- (4) Emergency room services:
- (5) Physician office services:
- (6) Diagnostic services:
- (7) Outpatient services, including therapy services:
- (8) Comprehensive disease management:
- (9) Home health services, including case management:
- (10) Urgent care center services:
- (11) Preventative care services:
- (12) Family planning services:
 - (A) including contraceptives and sexually transmitted disease testing, as described in federal Medicaid law (42 U.S.C. 1396 et seq.); and
 - (B) not including abortion or abortifacients:
- (13) Hospice services:
- (14) Substance abuse services:
- (15) A service determined by the secretary to be required by federal law as a benchmark service under the federal Patient Protection and Affordable Care Act.

(b) The plan may do the following:

- (1) Offer coverage for dental and vision services to an individual who participates in the plan:
- (2) Pay at least fifty percent (50%) of the premium cost of dental and vision services coverage described in subdivision (1):

(c) An individual who receives the dental or vision coverage offered under subsection (b) shall pay an amount determined by the office for the coverage. The office shall limit the payment to not more than five percent (5%) of the individual's annual household income. The payment required under this subsection is in addition to the payment required under section 11(b)(2) of this chapter for coverage under the plan:

(d) Vision services offered by the plan must include services provided by an optometrist:

(e) The plan must comply with any coverage requirements that



apply to an accident and sickness insurance policy issued in Indiana:

(f) The plan may not permit treatment limitations or financial requirements on the coverage of mental health care services or substance abuse services if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical conditions:

SECTION 9. IC 12-15-44.2-5 IS REPEALED [EFFECTIVE JULY 1, 2016]. Sec. 5: (a) The office shall provide to an individual who participates in the plan a list of health care services that qualify as preventative care services for the age, gender, and preexisting conditions of the individual. The office shall consult with the federal Centers for Disease Control and Prevention for a list of recommended preventative care services:

(b) The plan shall, at no cost to the individual, provide payment for not more than five hundred dollars (\$500) of qualifying preventative care services per year for an individual who participates in the plan. Any additional preventative care services covered under the plan and received by the individual during the year are subject to the deductible and payment requirements of the plan:

SECTION 10. IC 12-15-44.2-6 IS REPEALED [EFFECTIVE JULY 1, 2016]. Sec. 6: To the extent allowed by federal law, the plan has the following per participant coverage limitations:

- (1) An annual individual maximum coverage limitation of three hundred thousand dollars (\$300,000);
- (2) A lifetime individual maximum coverage limitation of one million dollars (\$1,000,000):

SECTION 11. IC 12-15-44.2-7 IS REPEALED [EFFECTIVE JULY 1, 2016]. Sec. 7: The following requirements apply to funds appropriated by the general assembly to the plan:

- (1) At least eighty-five percent (85%) of the funds must be used to fund payment for health care services;
- (2) An amount determined by the office of the secretary to fund:
 - (A) administrative costs of; and
 - (B) any profit made by;
 - an insurer or a health maintenance organization under a contract with the office to provide health insurance coverage under the plan. The amount determined under this subdivision may not exceed fifteen percent (15%) of the funds:

SECTION 12. IC 12-15-44.2-8 IS REPEALED [EFFECTIVE JULY 1, 2016]. Sec. 8: The plan is not an entitlement program. The maximum enrollment of individuals who may participate in the plan is dependent on funding appropriated for the plan:



SECTION 13. IC 12-15-44.2-9 IS REPEALED [EFFECTIVE JULY 1, 2016]. Sec. 9: (a) An individual is eligible for participation in the plan if the individual meets the following requirements:

(1) The individual is at least eighteen (18) years of age and less than sixty-five (65) years of age:

(2) The individual is a United States citizen and has been a resident of Indiana for at least twelve (12) months:

(3) The individual has an annual household income of not more than the following:

(A) Effective through December 31, 2013, two hundred percent (200%) of the federal income poverty level:

(B) Beginning January 1, 2014, one hundred thirty-three percent (133%) of the federal income poverty level, based on the adjusted gross income provisions set forth in Section 2001(a)(1) of the federal Patient Protection and Affordable Care Act:

(4) Effective through December 31, 2013, the individual is not eligible for health insurance coverage through the individual's employer:

(5) Effective through December 31, 2013, the individual has:

(A) not had health insurance coverage for at least six (6) months; or

(B) had coverage under the Indiana comprehensive health insurance association (IC 27-8-10) within the immediately preceding six (6) months and the coverage no longer applies under IC 27-8-10-0.5:

(b) The following individuals are not eligible for the plan:

(1) An individual who participates in the federal Medicare program (42 U.S.C. 1395 et seq.):

(2) An individual who is otherwise eligible for medical assistance:

(c) The eligibility requirements specified in subsection (a) are subject to approval for federal financial participation by the United States Department of Health and Human Services:

SECTION 14. IC 12-15-44.2-10 IS REPEALED [EFFECTIVE JULY 1, 2016]. Sec. 10: (a) An individual who participates in the plan must have a health care account to which payments may be made for the individual's participation in the plan only by the following:

(1) The individual:

(2) An employer:

(3) The state:

(4) A nonprofit organization if the nonprofit organization:

(A) is not affiliated with a health care plan; and



- (B) does not contribute more than seventy-five percent (75%) of the individual's required payment to the individual's health care account.
- (5) An insurer or a health maintenance organization under a contract with the office to provide health insurance coverage under the plan if the payment:
 - (A) is to provide a health incentive to the individual;
 - (B) does not count towards the individual's required minimum payment set forth in section 11 of this chapter; and
 - (C) does not exceed one thousand one hundred dollars (\$1,100).
- (b) The minimum funding amount for a health care account is the amount required under section 11 of this chapter.
- (c) An individual's health care account must be used to pay the individual's deductible for health care services under the plan.
- (d) An individual may make payments to the individual's health care account as follows:
 - (1) An employer withholding or causing to be withheld from an employee's wages or salary; after taxes are deducted from the wages or salary; the individual's contribution under this chapter and distributed equally throughout the calendar year.
 - (2) Submission of the individual's contribution under this chapter to the office to deposit in the individual's health care account in a manner prescribed by the office.
 - (3) Another method determined by the office.
- (e) An employer may make, from funds not payable by the employer to the employee; not more than fifty percent (50%) of an individual's required payment to the individual's health care account.
- (f) A nonprofit corporation may make not more than seventy-five percent (75%) of an individual's required payment to the individual's health care account.

SECTION 15. IC 12-15-44.2-11 IS REPEALED [EFFECTIVE JULY 1, 2016]. Sec. 11: (a) An individual's participation in the plan does not begin until an initial payment is made for the individual's participation in the plan. A required payment to the plan for the individual's participation may not exceed one-twelfth (1/12) of the annual payment required under subsection (b):

- (b) To participate in the plan; an individual shall do the following:
 - (1) Apply for the plan on a form prescribed by the office. The office may develop and allow a joint application for a household.
 - (2) If the individual is approved by the office to participate in the plan; contribute to the individual's health care account the lesser



of the following:

(A) One thousand one hundred dollars (\$1,100) per year; less any amounts paid by the individual under the:

- (i) Medicaid program under IC 12-15;
- (ii) children's health insurance program under IC 12-17.6; and
- (iii) Medicare program (42 U.S.C. 1395 et seq.);

as determined by the office:

(B) At least one hundred sixty dollars (\$160) per year and not more than the following applicable percentage of the individual's annual household income per year; less any amounts paid by the individual under the Medicaid program under IC 12-15; the children's health insurance program under IC 12-17.6; and the Medicare program (42 U.S.C. 1395 et seq.) as determined by the office:

- (i) Two percent (2%) of the individual's annual household income per year if the individual has an annual household income of not more than one hundred percent (100%) of the federal income poverty level;
- (ii) Three percent (3%) of the individual's annual household income per year if the individual has an annual household income of more than one hundred percent (100%) and not more than one hundred twenty-five percent (125%) of the federal income poverty level;
- (iii) Four percent (4%) of the individual's annual household income per year if the individual has an annual household income of more than one hundred twenty-five percent (125%) and not more than one hundred fifty percent (150%) of the federal income poverty level;
- (iv) Five percent (5%) of the individual's annual household income per year if the individual has an annual household income of more than one hundred fifty percent (150%) and not more than two hundred percent (200%) of the federal income poverty level;

(c) The state shall contribute the difference to the individual's account if the individual's payment required under subsection (b)(2) is less than one thousand one hundred dollars (\$1,100):

(d) If an individual's required payment to the plan is not made within sixty (60) days after the required payment date, the individual may be terminated from participation in the plan. The individual must receive written notice before the individual is terminated from the plan.

(e) After termination from the plan under subsection (d), the



individual may not reapply to participate in the plan for twelve (12) months.

SECTION 16. IC 12-15-44.2-12 IS REPEALED [EFFECTIVE JULY 1, 2016]. Sec. 12: (a) An individual who is approved to participate in the plan is eligible for a twelve (12) month plan period. An individual who participates in the plan may not be refused renewal of participation in the plan for the sole reason that the plan has reached the plan's maximum enrollment.

(b) If the individual chooses to renew participation in the plan, the individual shall complete a renewal application and any necessary documentation, and submit to the office the documentation and application on a form prescribed by the office.

(c) If the individual chooses not to renew participation in the plan, the individual may not reapply to participate in the plan for at least twelve (12) months.

(d) Any funds remaining in the health care account of an individual who renews participation in the plan at the end of the individual's twelve (12) month plan period must be used to reduce the individual's payments for the subsequent plan period. However, if the individual did not, during the plan period, receive all qualified preventative services recommended as provided in section 5 of this chapter, the state's contribution to the health care account may not be used to reduce the individual's payments for the subsequent plan period.

(e) If an individual is no longer eligible for the plan, does not renew participation in the plan at the end of the plan period, or is terminated from the plan for nonpayment of a required payment, the office shall, not more than sixty (60) days after the last date of participation in the plan, refund to the individual the amount determined under subsection (f) of any funds remaining in the individual's health care account as follows:

(1) An individual who is no longer eligible for the plan or does not renew participation in the plan at the end of the plan period shall receive the amount determined under STEP FOUR of subsection (f);

(2) An individual who is terminated from the plan due to nonpayment of a required payment shall receive the amount determined under STEP FIVE of subsection (f);

(f) The office shall determine the amount payable to an individual described in subsection (e) as follows:

STEP ONE: Determine the total amount paid into the individual's health care account under section 10(d) of this chapter.

STEP TWO: Determine the total amount paid into the individual's



health care account from all sources:

STEP THREE: Divide STEP ONE by STEP TWO:

STEP FOUR: Multiply the ratio determined in STEP THREE by the total amount remaining in the individual's health care account:

STEP FIVE: Multiply the amount determined under STEP FOUR by seventy-five hundredths (0.75):

SECTION 17. IC 12-15-44.2-13 IS REPEALED [EFFECTIVE JULY 1, 2016]. Sec. 13: Subject to appeal to the office, an individual may be held responsible under the plan for receiving nonemergency services in an emergency room setting, including prohibiting the individual from using funds in the individual's health care account to pay for the nonemergency services. However, an individual may not be prohibited from using funds in the individual's health care account to pay for nonemergency services provided in an emergency room setting for a medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to:

- (1) place an individual's health in serious jeopardy;
- (2) result in serious impairment to the individual's bodily functions; or
- (3) result in serious dysfunction of a bodily organ or part of the individual:

SECTION 18. IC 12-15-44.2-14 IS REPEALED [EFFECTIVE JULY 1, 2016]. Sec. 14: (a) An insurer or health maintenance organization that contracts with the office to provide health insurance coverage, dental coverage, or vision coverage to an individual who participates in the plan:

- (1) is responsible for the claim processing for the coverage;
- (2) shall reimburse providers at a rate that is not less than the rate established by the secretary. The rate set by the secretary must be based on a reimbursement formula that is:
 - (A) comparable to the federal Medicare reimbursement rate for the service provided by the provider; or
 - (B) one hundred thirty percent (130%) of the Medicaid reimbursement rate for a service that does not have a Medicare reimbursement rate; and
- (3) may not deny coverage to an eligible individual who has been approved by the office to participate in the plan, unless the individual has met the coverage limitations described in section 6 of this chapter:



(b) An insurer or a health maintenance organization that contracts with the office to provide health insurance coverage under the plan must incorporate cultural competency standards established by the office. The standards must include standards for non-English speaking, minority, and disabled populations.

SECTION 19. IC 12-15-44.2-16 IS REPEALED [EFFECTIVE JULY 1, 2016]. Sec. 16: (a) An insurer or a health maintenance organization that contracts with the office to provide health insurance coverage under the plan or an affiliate of an insurer or a health maintenance organization that contracts with the office to provide health insurance coverage under the plan shall offer to provide the same health insurance coverage to an individual who:

- (1) has not had health insurance coverage during the previous six (6) months; and
- (2) does not meet the eligibility requirements specified in section 9 of this chapter for participation in the plan.

(b) An insurer, a health maintenance organization, or an affiliate described in subsection (a) may apply to health insurance coverage offered under subsection (a) the insurer's, health maintenance organization's, or affiliate's standard individual or small group insurance underwriting and rating practices:

(c) The state does not provide funding for health insurance coverage received under this section:

SECTION 20. IC 12-15-44.2-18 IS REPEALED [EFFECTIVE JULY 1, 2016]. Sec. 18: (a) The office may not:

- (1) enroll applicants;
- (2) approve any contracts with vendors to provide services or administer the plan;
- (3) incur costs other than costs necessary to study and plan for the implementation of the plan; or
- (4) create financial obligations for the state;

unless both of the conditions of subsection (b) are satisfied:

(b) The office may not take any action described in subsection (a) unless:

- (1) there is a specific appropriation from the general assembly to implement the plan; and
- (2) after review by the budget committee, the budget agency approves an actuarial analysis that reflects a determination that sufficient funding is reasonably estimated to be available to operate the plan for at least the following five (5) years:

The actuarial analysis approved under subdivision (2) must clearly indicate the cost and revenue assumptions used in reaching the



determination:

(c) The office may not operate the plan in a manner that would obligate the state to financial participation beyond the level of state appropriations authorized for the plan.

SECTION 21. IC 12-15-44.2-19 IS REPEALED [EFFECTIVE JULY 1, 2016]. Sec. 19: (a) The office may adopt rules under IC 4-22-2 necessary to implement:

(1) this chapter; or

(2) a Section 1115 Medicaid demonstration waiver concerning the plan that is approved by the United States Department of Health and Human Services.

(b) The office may adopt emergency rules under IC 4-22-2-37.1 to implement the plan on an emergency basis.

(c) An emergency rule or an amendment to an emergency rule adopted under this section expires not later than the earlier of:

(1) one (1) year after the rule is accepted for filing under IC 4-22-2-37.1(e); or

(2) July 1, 2016.

SECTION 22. IC 12-15-44.2-20, AS AMENDED BY P.L.160-2011, SECTION 13, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: Sec. 20. (a) The office may establish a health insurance coverage premium assistance program for individuals who meet the following:

(1) Have an annual household income of the following:

(A) Through December 31, 2013, not more than two hundred percent (200%) of the federal income poverty level.

(B) Beginning January 1, 2014, not more than one hundred thirty-three percent (133%) of the federal income poverty level, based on the adjusted gross income provisions set forth in Section 2001(a)(1) of the federal Patient Protection and Affordable Care Act.

(2) Are eligible for health insurance coverage through an employer but cannot afford the health insurance coverage premiums.

(b) A program established under this section must:

(1) contain eligibility requirements that are similar to the eligibility requirements of the plan;

(2) include a health care account as a component; and

(3) provide that an individual's payment:

(A) to a health care account; or

(B) for a health insurance coverage premium;

may not exceed five percent (5%) of the individual's annual



income.

(c) The office may adopt rules under IC 4-22-2 necessary to implement and administer this section.

SECTION 23. IC 12-15-44.2-21 IS REPEALED [EFFECTIVE JULY 1, 2016]. Sec. 21: (a) A denial of federal approval and federal financial participation that applies to any part of this chapter does not prohibit the office from implementing any other part of this chapter that:

- (1) is federally approved for federal financial participation; or
- (2) does not require federal approval or federal financial participation.

(b) The secretary may make changes to the plan under this chapter if the changes are required by one (1) of the following:

- (1) The United States Department of Health and Human Services;
- (2) Federal law or regulation.

SECTION 24. IC 12-15-44.2-22 IS REPEALED [EFFECTIVE JULY 1, 2016]. Sec. 22: The office of the secretary may amend the plan in a manner that would allow Indiana to use the plan to cover individuals eligible for Medicaid resulting from passage of the Federal Patient Protection and Affordable Care Act.

SECTION 25. IC 12-15-44.5-2, AS ADDED BY P.L.213-2015, SECTION 136, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: Sec. 2. As used in this chapter, "plan" refers to the healthy Indiana plan ~~2-0~~ established by section 3 of this chapter.

SECTION 26. IC 12-15-44.5-2.3 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: Sec. 2.3. As used in this chapter, "preventative care services" means care that is provided to an individual to prevent disease, diagnose disease, or promote good health.

SECTION 27. IC 12-15-44.5-3, AS ADDED BY P.L.213-2015, SECTION 136, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: Sec. 3. (a) The healthy Indiana plan ~~2-0~~ is established. This chapter is in addition to the provisions set forth in IC 12-15-44.2. For the period beginning February 1, 2015, and ending the date the plan is terminated upon the completion of a phase out period; if a provision in this chapter conflicts with IC 12-15-44.2, this chapter supersedes the conflicting provision in IC 12-15-44.2.

(b) The office shall administer the plan.

(c) The following individuals are eligible for the plan:

- (1) An individual who is eligible and described in



~~IC 12-15-44.2-9:~~

~~(2) (1)~~ The adult group described in 42 CFR 435.119.

~~(3) Pregnant women who choose to remain in the plan during the pregnancy:~~

~~(4) (2)~~ Parents and caretaker relatives eligible under 42 CFR 435.110.

~~(5) (3)~~ Low income individuals who are:

(A) at least nineteen (19) years of age; and

(B) less than twenty-one (21) years of age;

and eligible under 42 CFR 435.222.

~~(6) (4)~~ Individuals, for purposes of receiving transitional medical assistance.

An individual must meet the Medicaid residency requirements under IC 12-15-4-4 and this article to be eligible for the plan.

(d) The following individuals are not eligible for the plan:

(1) An individual who participates in the federal Medicare program (42 U.S.C. 1395 et seq.).

(2) ~~Except for an individual described in subsection (c);~~ An individual who is otherwise eligible **and enrolled** for medical assistance.

(e) The department of insurance and the office of the secretary shall provide oversight of the marketing practices of the plan.

(f) The office shall promote the plan and provide information to potential eligible individuals who live in medically underserved rural areas of Indiana.

(g) The office shall, to the extent possible, ensure that enrollment in the plan is distributed throughout Indiana in proportion to the number of individuals throughout Indiana who are eligible for participation in the plan.

(h) The office shall establish standards for consumer protection, including the following:

(1) Quality of care standards.

(2) A uniform process for participant grievances and appeals.

(3) Standardized reporting concerning provider performance, consumer experience, and cost.

(i) A health care provider that provides care to an individual who receives health insurance coverage under the plan shall also participate in the Medicaid program under this article.

(j) The following do not apply to the plan:

(1) IC 12-15-6.

(2) IC 12-15-12.

(3) IC 12-15-13.



- (4) IC 12-15-14.
- (5) IC 12-15-15.
- (6) IC 12-15-21.
- (7) IC 12-15-26.
- (8) IC 12-15-31.1.
- (9) IC 12-15-34.
- (10) IC 12-15-35.
- (11) IC 16-42-22-10.

SECTION 28. IC 12-15-44.5-3.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: **Sec. 3.5. (a) The plan must include the following in a manner and to the extent determined by the office:**

- (1) Mental health care services.
- (2) Inpatient hospital services.
- (3) Prescription drug coverage, including coverage of a long acting, nonaddictive medication assistance treatment drug if the drug is being prescribed for the treatment of substance abuse.
- (4) Emergency room services.
- (5) Physician office services.
- (6) Diagnostic services.
- (7) Outpatient services, including therapy services.
- (8) Comprehensive disease management.
- (9) Home health services, including case management.
- (10) Urgent care center services.
- (11) Preventative care services.
- (12) Family planning services:
 - (A) including contraceptives and sexually transmitted disease testing, as described in federal Medicaid law (42 U.S.C. 1396 et seq.); and
 - (B) not including abortion or abortifacients.
- (13) Hospice services.
- (14) Substance abuse services.
- (15) Pregnancy services.
- (16) A service determined by the secretary to be required by federal law as a benchmark service under the federal Patient Protection and Affordable Care Act.

(b) The plan may not permit treatment limitations or financial requirements on the coverage of mental health care services or substance abuse services if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical conditions.



(c) The plan may provide vision services and dental services only to individuals who regularly make the required monthly contributions for the plan as set forth in section 4.7(c) of this chapter.

(d) The benefit package offered in the plan:

(1) must be benchmarked to a commercial health plan described in 45 CFR 155.100(a)(1) or 45 CFR 155.100(a)(4); and

(2) may not include a benefit that is not present in at least one (1) of these commercial benchmark options.

(e) The office shall provide to an individual who participates in the plan a list of health care services that qualify as preventative care services for the age, gender, and preexisting conditions of the individual. The office shall consult with the federal Centers for Disease Control and Prevention for a list of recommended preventative care services.

(f) The plan shall, at no cost to the individual, provide payment of preventative care services described in 42 U.S.C. 300gg-13 for an individual who participates in the plan.

(g) The plan shall, at no cost to the individual, provide payments of not more than five hundred dollars (\$500) per year for preventative care services not described in subsection (f). Any additional preventative care services covered under the plan and received by the individual during the year are subject to the deductible and payment requirements of the plan.

SECTION 29. IC 12-15-44.5-4, AS ADDED BY P.L.213-2015, SECTION 136, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: Sec. 4. (a) The plan:

(1) is not an entitlement program; and

(2) serves as an alternative to health care coverage under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.).

(b) If either of the following occurs, the office shall terminate the plan in accordance with section 6(b) of this chapter:

(1) The:

(A) percentages of federal medical assistance available to the plan for coverage of plan participants described in Section 1902(a)(10)(A)(i)(VIII) of the federal Social Security Act are less than the percentages provided for in Section 2001(a)(3)(B) of the federal Patient Protection and Affordable Care Act; and

(B) hospital assessment committee (IC 16-21-10), after considering the modification and the reduction in available



funding, does not alter the formula established under IC 16-21-10-13.3(b)(1) to cover the amount of the reduction in federal medical assistance.

For purposes of this subdivision, "coverage of plan participants" includes payments, contributions, and amounts referred to in IC 16-21-10-13.3(b)(1)(A), IC 16-21-10-13.3(b)(1)(C), and IC 16-21-10-13.3(b)(1)(D), including payments, contributions, and amounts incurred during a phase out period of the plan.

(2) The:

(A) methodology of calculating the incremental fee set forth in IC 16-21-10-13.3 is modified in any way that results in a reduction in available funding;

(B) hospital assessment fee committee (IC 16-21-10), after considering the modification and reduction in available funding, does not alter the formula established under IC 16-21-10-13.3(b)(1) to cover the amount of the reduction in fees; and

(C) office does not use alternative financial support to cover the amount of the reduction in fees.

(c) If the plan is terminated under subsection (b), the secretary may implement a plan for coverage of the affected population in a manner consistent with the healthy Indiana plan (IC 12-15-44.2 **(before its repeal)**) in effect on January 1, 2014:

(1) subject to prior approval of the United States Department of Health and Human Services; and

(2) without funding from the incremental fee set forth in IC 16-21-10-13.3.

(d) The office may not operate the plan in a manner that would obligate the state to financial participation beyond the level of state appropriations or funding otherwise authorized for the plan.

(e) The office of the secretary shall submit annually to the budget committee an actuarial analysis of the plan that reflects a determination that sufficient funding is reasonably estimated to be available to operate the plan.

SECTION 30. IC 12-15-44.5-4.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: **Sec. 4.5. (a) An individual who participates in the plan must have a health care account to which payments may be made for the individual's participation in the plan.**

(b) An individual's health care account must be used to pay the individual's deductible for health care services under the plan.



(c) An individual's deductible must be at least two thousand five hundred dollars (\$2,500) per year.

(d) An individual may make payments to the individual's health care account as follows:

(1) An employer withholding or causing to be withheld from an employee's wages or salary, after taxes are deducted from the wages or salary, the individual's contribution under this chapter and distributed equally throughout the calendar year.

(2) Submission of the individual's contribution under this chapter to the office to deposit in the individual's health care account in a manner prescribed by the office.

(3) Another method determined by the office.

SECTION 31. IC 12-15-44.5-4.7 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: **Sec. 4.7. (a) To participate in the plan, an individual must apply for the plan on a form prescribed by the office. The office may develop and allow a joint application for a household.**

(b) A pregnant woman is not subject to the cost sharing provisions of the plan. Subsections (c) through (g) do not apply to a pregnant woman participating in the plan.

(c) An applicant who is approved to participate in the plan does not begin benefits under the plan until a payment of at least:

(1) one-twelfth (1/12) of the two percent (2%) of annual income contribution amount; or

(2) ten dollars (\$10);

is made to the individual's health care account established under section 4.5 of this chapter for the individual's participation in the plan. To continue to participate in the plan, an individual must contribute to the individual's health care account at least two percent (2%) of the individual's annual household income per year but not less than one dollar (\$1) per month.

(d) If an applicant who is approved to participate in the plan fails to make the initial payment into the individual's health care account, at least the following must occur:

(1) If the individual has an annual income that is at or below one hundred percent (100%) of the federal poverty income level, the individual's benefits are reduced as specified in subsection (e)(1).

(2) If the individual has an annual income of more than one hundred percent (100%) of the federal poverty income level, the individual is not enrolled in the plan.



(e) If an enrolled individual's required monthly payment to the plan is not made within sixty (60) days after the required payment date, the following, at a minimum, occur:

(1) For an individual who has an annual income that is at or below one hundred percent (100%) of the federal income poverty level, the individual is:

(A) transferred to a plan that has a material reduction in benefits, including the elimination of benefits for vision and dental services; and

(B) required to make copayments for the provision of services that may not be paid from the individual's health care account.

(2) For an individual who has an annual income of more than one hundred percent (100%) of the federal poverty income level, the individual shall be terminated from the plan and may not reenroll in the plan for at least six (6) months.

(f) The state shall contribute to the individual's health care account the difference between the individual's payment required under this section and the plan deductible set forth in section 4.5(c) of this chapter.

(g) A member shall remain enrolled with the same health plan during the member's benefit period. A member may change health plans as follows:

(1) Without cause:

(A) before making a contribution or before finalizing enrollment in accordance with subsection (d)(1); or

(B) during the annual plan renewal process.

(2) For cause, as determined by the office.

SECTION 32. IC 12-15-44.5-4.9 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: Sec. 4.9. (a) An individual who is approved to participate in the plan is eligible for a twelve (12) month plan period if the individual continues to meet the plan requirements specified in this chapter.

(b) If an individual chooses to renew participation in the plan, the individual is subject to an annual renewal process at the end of the benefit period to determine continued eligibility for participating in the plan. If the individual does not complete the renewal process, the individual may not reenroll in the plan for at least six (6) months.

(c) This subsection applies to participants who consistently made the required payments in the individual's health care



account. If the individual receives the qualified preventative services recommended to the individual during the year, the individual is eligible to have the individual's unused share of the individual's health care account at the end of the plan period, determined by the office, matched by the state and carried over to the subsequent plan period to reduce the individual's required payments. If the individual did not, during the plan period, receive all qualified preventative services recommended to the individual, only the nonstate contribution to the health care account may be used to reduce the individual's payments for the subsequent plan period.

(d) For individuals participating in the plan who, in the past, did not make consistent payments into the individual's health care account while participating in the plan, but:

(1) had a balance remaining in the individual's health care account; and

(2) received all of the required preventative care services; the office may elect to offer a discount on the individual's required payments to the individual's health care account for the subsequent benefit year. The amount of the discount under this subsection must be related to the percentage of the health care account balance at the end of the plan year but not to exceed a fifty percent (50%) discount of the required contribution.

(e) If an individual is no longer eligible for the plan, does not renew participation in the plan at the end of the plan period, or is terminated from the plan for nonpayment of a required payment, the office shall, not more than one hundred twenty (120) days after the last date of participation in the plan, refund to the individual the amount determined under subsection (f) of any funds remaining in the individual's health care account as follows:

(1) An individual who is no longer eligible for the plan or does not renew participation in the plan at the end of the plan period shall receive the amount determined under STEP FOUR of subsection (f).

(2) An individual who is terminated from the plan due to nonpayment of a required payment shall receive the amount determined under STEP SIX of subsection (f).

The office may charge a penalty for any voluntary withdrawals from the health care account by the individual before the end of the plan benefit year. The individual may receive the amount determined under STEP SIX of subsection (f).

(f) The office shall determine the amount payable to an



individual described in subsection (e) as follows:

STEP ONE: Determine the total amount paid into the individual's health care account under this chapter.

STEP TWO: Determine the total amount paid into the individual's health care account from all sources.

STEP THREE: Divide STEP ONE by STEP TWO.

STEP FOUR: Multiply the ratio determined in STEP THREE by the total amount remaining in the individual's health care account.

STEP FIVE: Subtract any nonpayments of a required payment.

STEP SIX: Multiply the amount determined under STEP FIVE by at least seventy-five hundredths (0.75).

SECTION 33. IC 12-15-44.5-5.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: **Sec. 5.5.** The office shall refer any member of the plan who:

- (1) is employed for less than twenty (20) hours per week; and
- (2) is not a full-time student;

to a workforce training and job search program.

SECTION 34. IC 12-15-44.5-5.7 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: **Sec. 5.7.** Subject to appeal to the office, an individual may be held responsible under the plan for receiving nonemergency services in an emergency room setting, including prohibiting the individual from using funds in the individual's health care account to pay for the nonemergency services and paying a copayment for the services of at least eight dollars (\$8) for the first nonemergency use of a hospital emergency department and at least a twenty-five dollar (\$25) copayment for any subsequent nonemergency use of a hospital emergency department during the benefit period. However, an individual may not be prohibited from using funds in the individual's health care account to pay for nonemergency services provided in an emergency room setting for a medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to:

- (1) place an individual's health in serious jeopardy;
- (2) result in serious impairment to the individual's bodily



functions; or

(3) result in serious dysfunction of a bodily organ or part of the individual.

SECTION 35. IC 12-15-44.5-10, AS ADDED BY P.L.213-2015, SECTION 136, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: Sec. 10. (a) The secretary ~~may make changes to the plan under this chapter if the changes are required by one (1) of the following:~~

~~(1) The United States Department of Health and Human Services;~~

~~(2) Federal law or regulation;~~

has the authority to provide benefits to individuals eligible under the adult group described in 42 CFR 435.119 only in accordance with this chapter.

(b) The secretary may negotiate and make changes to the plan, except that the secretary may not negotiate or change the plan that would do the following:

(1) Reduce the following:

(A) Contribution amounts below the minimum levels set forth in section 4.7 of this chapter.

(B) Deductible amounts below the minimum amount established in section 4.5(c) of this chapter.

(2) Remove or reduce the penalties for nonpayment set forth in section 4.7 of this chapter.

(3) Revise the use of the health care account requirement set forth in section 4.5 of this chapter.

(4) Include noncommercial benefits or add additional plan benefits in a manner inconsistent with section 3.5 of this chapter.

(5) Allow services to begin:

(A) without the payment established or required by; or

(B) earlier than the time frames otherwise established by; section 4.7 of this chapter.

(6) Reduce financial penalties for the inappropriate use of the emergency room below the minimum levels set forth in section 5.7 of this chapter.

(7) Permit members to change health plans without cause in a manner inconsistent with section 4.7(g) of this chapter.

(8) Operate the plan in a manner that would obligate the state to financial participation beyond the level of state appropriations or funding otherwise authorized for the plan.

(c) The secretary may make changes to the plan under this chapter if the changes are required by federal law or regulation.



SECTION 36. IC 16-18-2-187.2, AS ADDED BY P.L.213-2015, SECTION 138, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: Sec. 187.2. "Incremental fee", for purposes of IC 16-21-10, means a part of the hospital assessment fee designated for the use of funding the healthy Indiana plan. ~~2-0-~~

SECTION 37. IC 16-21-10-5.3, AS ADDED BY P.L.213-2015, SECTION 140, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: Sec. 5.3. As used in this chapter, "phase out period" refers to the following periods:

- (1) The time during which a:
 - (A) phase out plan;
 - (B) demonstration expiration plan; or
 - (C) similar plan approved by the United States Department of Health and Human Services;

is in effect for the healthy Indiana plan ~~2-0~~ set forth in IC 12-15-44.5.

- (2) The time beginning upon the office's receipt of written notice by the United States Department of Health and Human Services of its decision to:

- (A) terminate or suspend the waiver demonstration for the healthy Indiana plan; ~~2-0~~; or
 - (B) withdraw the waiver or expenditure authority for the plan; and ~~ends~~ **ending** on the effective date of the termination, suspension, or withdrawal of the waiver or expenditure authority.

- (3) The time beginning upon:

- (A) the office's determination to terminate the healthy Indiana plan; ~~2-0~~; or
 - (B) the termination of the plan under IC 12-15-44.5-4(b);
- if subdivisions (1) through (2) do not apply, and ending on the effective date of the termination of the healthy Indiana plan. ~~2-0-~~

SECTION 38. IC 16-21-10-11, AS AMENDED BY P.L.213-2015, SECTION 145, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: Sec. 11. (a) This section:

- (1) does not apply to the incremental fee described in section 13.3 of this chapter;
 - (2) is effective upon the implementation of the fee described in section 6 of this chapter, excluding the part of the fee used for purposes of section 13.3 of this chapter; and
 - (3) applies to the Medicaid disproportionate share payments for the state fiscal year beginning July 1, 2013, and each state fiscal year thereafter.
- (b) The state share dollars used to fund disproportionate share



payments to acute care hospitals licensed under IC 16-21-2 that qualify as disproportionate share providers or municipal disproportionate share providers under IC 12-15-16-1(a) or IC 12-15-16-1(b) shall be paid with money collected through the fee and the hospital care for the indigent dollars described in section 10 of this chapter.

(c) ~~Subject to section 12 of this chapter, and except as provided in section 12 of this chapter,~~ The federal Medicaid disproportionate share allotments for the state fiscal years beginning July 1, 2013, and each state fiscal year thereafter shall be allocated in their entirety to acute care hospitals licensed under IC 16-21-2 that qualify as disproportionate share providers or municipal disproportionate share providers under IC 12-15-16-1(a) or IC 12-15-16-1(b). No part of the federal disproportionate share allotments applicable for disproportionate share payments for the state fiscal year beginning July 1, 2013, and each state fiscal year thereafter may be allocated to institutions for mental disease or other mental health facilities, as defined by applicable federal law.

SECTION 39. IC 16-21-10-12 IS REPEALED [EFFECTIVE JULY 1, 2016]. ~~Sec. 12: This section does not apply to the use of the incremental fee described in section 13.3 of this chapter. For purposes of this chapter, the entire federal Medicaid disproportionate share allotment for Indiana does not include the part of allotments that are required to be diverted under the following:~~

(1) The federally approved Indiana "Special Terms and Conditions" Medicaid demonstration project (Number 11-W-00237/5);

(2) ~~Any extension after December 31, 2012, of the healthy Indiana plan established under IC 12-15-44.2.~~

~~The office shall inform the committee and the budget committee concerning any extension of the healthy Indiana plan after December 31, 2013.~~

SECTION 40. IC 16-21-10-13.3, AS ADDED BY P.L.213-2015, SECTION 148, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: Sec. 13.3. (a) This section is effective beginning February 1, 2015. As used in this section, "plan" refers to the healthy Indiana plan ~~2-0~~ established in IC 12-15-44.5.

(b) Subject to subsections (c) through (e), the incremental fee under this section may be used to fund the state share of the expenses specified in this subsection if, after January 31, 2015, but before the collection of the fee under this section, the following occur:

(1) The committee establishes a fee formula to be used to fund the state share of the following expenses described in this



subdivision:

- (A) The state share of the capitated payments made to a managed care organization that contracts with the office to provide health coverage under the plan to plan enrollees other than plan enrollees who are eligible for the plan under Section 1931 of the federal Social Security Act.
- (B) The state share of capitated payments described in clause (A) for plan enrollees who are eligible for the plan under Section 1931 of the federal Social Security Act that are limited to the difference between:
 - (i) the capitation rates effective September 1, 2014, developed using Medicaid reimbursement rates; and
 - (ii) the capitation rates applicable for the plan developed using the plan's Medicare reimbursement rates described in ~~IC 12-15-44.2-14(a)(2)~~ **IC 12-15-44.5-5(a)(2)**.
- (C) The state share of the state's contributions to plan enrollee accounts.
- (D) The state share of amounts used to pay premiums for a premium assistance plan implemented under IC 12-15-44.2-20.
- (E) The state share of the costs of increasing reimbursement rates for health care services provided to individuals enrolled in Medicaid programs other than the plan.
- (F) The state share of the state's administrative costs that, for purposes of this clause, may not exceed one hundred seventy dollars (\$170) per person per plan enrollee per year, and adjusted annually by the Consumer Price Index.
- (G) The money described in IC 12-15-44.5-6(a) for the phase out period of the plan.
- (2) The committee approves a process to be used for reconciling:
 - (A) the state share of the costs of the plan;
 - (B) the amounts used to fund the state share of the costs of the plan; and
 - (C) the amount of fees assessed for funding the state share of the costs of the plan.

For purposes of this subdivision, "costs of the plan" includes the costs of the expenses listed in subdivision (1)(A) through (1)(G). The fees collected under subdivision (1)(A) through (1)(F) shall be deposited into the incremental hospital fee fund established by section 13.5 of this chapter. Fees described in subdivision (1)(G) shall be deposited into the phase out trust fund described in IC 12-15-44.5-7. The fees used for purposes of funding the state share of expenses listed



in subdivision (1)(A) through (1)(F) may not be used to fund expenses incurred on or after the commencement of a phase out period of the plan.

(c) For each state fiscal year for which the fee authorized by this section is used to fund the state share of the expenses described in subsection (b)(1), the amount of fees shall be reduced by:

- (1) the amount of funds annually designated by the general assembly to be deposited in the healthy Indiana plan trust fund established by IC 12-15-44.2-17; less
- (2) the annual cigarette tax funds annually appropriated by the general assembly for childhood immunization programs under IC 12-15-44.2-17(a)(3).

(d) The incremental fee described in this section may not:

- (1) be assessed before July 1, 2016; and
- (2) be assessed or collected on or after the beginning of a phase out period of the plan.

(e) This section is not intended to and may not be construed to change or affect any component of the programs established under section 8 of this chapter.

SECTION 41. IC 16-21-10-13.5, AS ADDED BY P.L.213-2015, SECTION 149, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: Sec. 13.5. (a) The incremental hospital fee fund is established for the purpose of holding fees collected under section 13.3 of this chapter.

(b) The office shall administer the fund.

(c) Money in the fund consists of the following:

- (1) Fees collected under section 13.3 of this chapter.
- (2) Donations, gifts, and money received from any other source.
- (3) Interest accrued under this section.

(d) Money in the fund may be used only for the following:

- (1) To fund exclusively the state share of the expenses listed in section 13.3(b)(1)(A) through 13.3(b)(1)(F) of this chapter.
- (2) To refund hospitals in the same manner as described in subsection (g) as soon as reasonably possible after the beginning of a phase out period of the healthy Indiana plan. ~~2-0-~~

(e) Money remaining in the fund at the end of a state fiscal year does not revert to the state general fund.

(f) The treasurer of state shall invest the money in the fund not currently needed to meet the obligations of the fund in the same manner as other public funds may be invested. Interest that accrues from these investments shall be deposited in the fund.

(g) Upon the beginning of a phase out period of the healthy Indiana



plan, ~~2-0~~; money collected under section 13.3 of this chapter and any accrued interest remaining in the fund shall be distributed to the hospitals on a pro rata basis based upon the fees authorized by this chapter that were paid by each hospital for the state fiscal year that ended immediately before the beginning of the phase out period.

SECTION 42. IC 27-8-10.1 IS REPEALED [EFFECTIVE JULY 1, 2016]. (High Risk Indiana Check-Up Plan Participants).

SECTION 43. IC 27-19-2-15, AS AMENDED BY P.L.213-2015, SECTION 254, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: Sec. 15. (a) "Public health insurance program" refers to health coverage provided under a state or federal government program.

(b) The term includes the following:

(1) Medicaid (42 U.S.C. 1396 et seq.).

(2) The healthy Indiana plan established by ~~IC 12-15-44.2-3~~.
IC 12-15-44.5-3.

(3) The children's health insurance program established under IC 12-17.6.

SECTION 44. IC 36-2-13-19, AS ADDED BY P.L.185-2015, SECTION 29, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: Sec. 19. (a) This section applies to a person who:

(1) is subject to lawful detention;

(2) incurs or will incur medical care expenses that are not otherwise reimbursable during the lawful detention;

(3) is unwilling or unable to pay for the person's own health care services; and

(4) is potentially eligible for Medicaid (IC 12-15).

(b) For a person described in subsection (a), the sheriff is the person's Medicaid authorized representative and may apply for Medicaid on behalf of the person.

(c) A county executive and the office of the secretary of family and social services shall enter into a written memorandum of understanding providing that the sheriff shall reimburse the office of the secretary for administrative costs and the state share of the Medicaid costs incurred for a person described in this section.

(d) Reimbursement under this section for reimbursable health care services provided by a health care provider, including a hospital, to a person as an inpatient in a hospital must be as follows:

(1) For individuals eligible under the ~~Indiana check-up plan~~ (~~IC 12-15-44.2~~), **healthy Indiana plan (IC 12-15-44.5)**, the reimbursement rates described in ~~IC 12-15-44.2-14~~.
IC 12-15-44.5-5.



(2) For individuals other than those described in subdivision (1) who are eligible under the Medicaid program, the reimbursement rates provided under the Medicaid program, except that reimbursement for inpatient hospital services shall be reimbursed at rates equal to the fee-for-service rates described in IC 16-21-10-8(a)(1).

Hospital assessment fee funds collected under IC 16-21-10 or the Indiana check-up plan trust fund (IC 12-15-44.2-17) may not be used as the state share of Medicaid costs for the reimbursement of health care services provided to the person as an inpatient in the hospital.

(e) The state share of all claims reimbursed by Medicaid for a person described in subsection (a) shall be paid by the county.



President of the Senate

President Pro Tempore

Speaker of the House of Representatives

Governor of the State of Indiana

Date: _____ Time: _____

